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Recovery: past progress and future challenges

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Abstract (200 words)

The idea of 'recovery' now permeates a great deal of international mental health policy. In opening this themed issue on recovery, we address three related international issues. First, what does recovery mean, both for individuals experiencing mental illness and for mental health systems? The conceptual foundations and the practice implications of a recovery orientation have become much clearer in the past decade. Second, what are the key policy implementation challenges? Lessons from countries which are implementing pro-recovery mental health policy identify several issues: sociopolitical expectations on the mental health system; how to advance positive attitudes within organisational culture through workforce planning and performance management strategies; and the extent to which choice and power can be exercised by the consumer. Finally, we identify future research and practice priorities. Empirical research is needed to identify the contribution that mental health services can make to recovery. Also, and perhaps more importantly, research is needed to identify where problems (and therefore solutions) lie outside the traditional service delivery system such as disability rights, stigma, and societal responses to suffering. Maximising recovery support will likely involve incorporation of new types of evidence into mental health services, including research on well-being and positive psychology research.

What does 'recovery' mean?

In many countries and settings, there is still not a consensus about the term 'recovery' and its implications for policy and practice. In fact 'recovery' is at the heart of debates about the core purpose of mental health services. As such, it is a contested term, with two contrasting meanings. We begin by differentiating these two meanings.

The first meaning of recovery has emerged from professional-led research and practice, and can be summarised as returning to normal. For example, a widely-used definition is that recovery comprises full symptom remission, full or part-time work or education, independent living without supervision by informal carers, and having friends with whom activities can be shared, all sustained for a period of two years (Libermann & Kopelowicz, 2002). Recovery in this sense is observable, can be rated by an expert clinician, can be investigated using epidemiological research (Hopper, Harrison, Janca, & Sartorius, 2007), and has an invariant definition across individuals. This is often the meaning that professional training is oriented towards.

However, deep assumptions about normality are embedded in this definition with potentially negative implications - especially for service users. *This kind of definition begs several questions that need to be addressed to come up with an understanding of recovery as an outcome: How many goals must be achieved to be considered recovered? For that matter, how much life success is considered "normal"?* (Ralph, 2005) (p. 5). The user/survivor movement has become more organised, vocal and influential over the past 30-40 years; consistent with the principle of "nothing about me without me", people who use mental health services have called for a new approach: *The field of psychiatric disabilities requires an enriched knowledge base and literature to guide innovation in policy and practice under a recovery paradigm. We must reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event.* (Ridgway, 2001). An enriched knowledge base has been accruing, under the banner of a second meaning of 'recovery'.

People personally affected by mental illness have become increasingly vocal in communicating both what their life is like with the mental illness and what helps in moving beyond the role of a patient. Early accounts were written by individual pioneers (Coleman, 1999; Deegan, 1988; O'Hagan, 1996). Once individual stories were more visible, compilations and syntheses of these accounts began to emerge from around the (especially Anglophone) world, e.g. from Australia (Andresen, Oades, & Caputi, 2003), New Zealand (Barnett & Lapsley, 2006), Scotland (Scottish Recovery Network, 2007), the USA (Davidson, Sells, Sangster, & O'Connell, 2005) and England (McIntosh, 2005). The understanding of recovery which has emerged from these accounts has a different focus. The most widely-cited definition, which underpins most recovery policy internationally, was put forward by William Anthony in 1993: *Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or*

roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993). It is consistent with the less widely-cited but more succinct definition proposed by Retta Andresen and colleagues, that recovery involves the *establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination* (Andresen, et al., 2003). Perhaps the briefest definition is *Recovery involves living as well as possible* (South London and Maudsley NHS Foundation Trust, 2010). It is this second understanding of recovery derived from the service user movement that is used throughout the remainder of this issue of *International Review of Psychiatry*.

Mental health services and recovery

Although recovery has emerged from the lived experience of people experiencing what professionals understand as mental illness, scientific research is catching up in its ability to validate the assertions of service users and their families. Systematic reviews (Doughty & Tse, 2005; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), randomised controlled trials (Barbic, Krupa, & Armstrong, 2009; Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008), intervention manuals (Bird, Leamy, Le Boutillier, Williams, & Slade, 2011; Clarke, Oades, Crowe, & Deane, 2006), scholarly overviews (Andresen, Oades, & Caputi, 2011; Slade, 2009b) and practice guides (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009; Slade, 2009a) all contribute to a growing evidence base for recovery practice and outcomes. Consensus on best practice internationally is now emerging (Compagni, Adams, & Daniels, 2007; Le Boutillier et al., 2011), and links are being established with a wider and related literature on topics such as person-centred planning (Adams & Grieder, 2005), positive psychology (Resnick & Rosenheck, 2006) and well-being (Slade, 2010).

This research has been mirrored by a policy shift towards recovery as the central orientation for mental health services internationally. The shift has been clearest in the English-speaking world, but as the other papers in this editorial show, is spreading more widely.

Challenges

In the context of this widespread rhetorical support for recovery, we identify some central challenges in developing recovery-oriented mental health services.

For most mental health systems, moving away from traditional practice models and adopting recovery practices and changing systems has not been easy; the challenge is to understand the profound implications of this true paradigm shift and to support efforts at change. In the United States, for example, the needed changes have been described as transformational. A move towards supporting recovery involves re-organisation of power arrangements. For example, in recovery the expertise of the service user rather than that of the clinician is given

pre-eminence. This is sometimes summarised as *services on tap, not on top*. Since mental health services - like any human services system - are not naturally inclined to systemic transformation, there is a tendency to adopt new rhetoric without changing practice. This leads service users to fear that recovery is being “hijacked” by service delivery systems (Mental Health "Recovery" Study Working Group, 2009), or that it is being used as a ‘cover’ for service reduction and reducing welfare support (Mind, 2008).

Once the scale of challenge to truly move from practice as usual to recovery is grasped, new issues emerge. Is a recovery-oriented mental health system compatible with socio-political expectations that a mental health system will manage risk and provide social control? Can we develop recovery-based services when stigma and discrimination are still rife in services and society? Can we move onto recovery-based services before the mental health system publicly acknowledges harm it has caused? Does the very existence of a mental health system inhibit the development of a socially inclusive society, by reinforcing a distinction between people with and without mental illness? More prosaically, how in practice do we make the transition from crisis-driven clinical services to a broad range of supports, resources and opportunities that facilitate recovery and well-being (Le Boutillier, et al., 2011)? How can mental health professionals and service users change established hierarchical interpersonal patterns and instead move towards more egalitarian and partnership-based ways of working together? Should mental health workers spend their time treating individuals or become agents of social change? Whether the existing workforce can develop new competencies (O'Hagan, 2001) is of real concern. Perhaps including more Peer Support Workers (e.g. 50% - (Shepherd, Boardman, & Burns, 2010)) should be a major component of a transformed system?

Research challenges also remain (Slade & Hayward, 2007). Empirical research is needed to identify the contribution that mental health services can - and cannot - make to recovery (Slade et al., 2011). Also, and perhaps more importantly, research is needed to identify cross sectoral challenges and opportunities, including linkages with disability rights, stigma, and societal responses to suffering.

The ten international papers in this issue of the Journal directly address all these concerns. Efforts to translate pro-recovery policy into practice are described [Piat paper, this issue], including top-down and bottom-up approaches to organisational transformation [Perkins England paper, this issue], increasing access to citizenship entitlements [Roe Israel paper, this issue], the role of community based learning approaches [Bradstreet Scotland paper, this issue] and links with broader well-being agendas [O'Hagan New Zealand paper, this issue]. Descriptions are given of approaches to amplifying strengths [Oades Australia paper, this issue], providing person-centred care [Salvador Carulla Spain paper, this issue] and developing peer support specialists [Adams USA paper, this issue], along with methods of changing how staff and service users

relate to each other [Amering Austria paper, this issue] and increasing participation in services [Tse Hong Kong paper, this issue].

Consistent with the social rights value of 'nothing about us without us' and partnership at the core of recovery practice, papers in this issue are written by a mix of people with professional and lived experience. We hope the papers provide a helpful stock-take of where we are in supporting recovery internationally.

Declaration of interests

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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